COUNTY OF LOS ANGELES
DEPARTMENT OF AUDITOR-CONTROLLER

KENNETH HAHN HALL OF ADMINISTRATION
500 WEST TEMPLE STREET, ROOM 525
LOS ANGELES, CALIFORNIA 90012-3873
PHONE: (213) 974-8301 FAX: (213) 626-5427

JOHN NAIMO
AUDITOR-CONTROLLER

August 14, 2015

TO: Supervisor Michael D. Antonovich, Mayor
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Don Knabe

FROM: John Naimo
Auditor-Controller

SUBJECT: **MENTAL HEALTH DIVERSION PROGRAMS REVIEW STAGE 1 – PRE-ARREST LAW ENFORCEMENT DIVERSION**

In July 2014, your Board instructed the Auditor-Controller, in consultation with several departments, to develop a methodologically sound formula recommendation for how much the County should invest in mental health diversion on an ongoing basis.

We discussed mental health diversion with relevant departments and determined that it would not be practical to identify an appropriate level of investment at this time because the County is currently in the process of developing comprehensive diversion programs. In addition, recent laws have added significant uncertainty regarding the number of people who will need services (e.g., Proposition 47, Assembly Bill 109, etc.). As a result, our review focuses on identifying planned mental health diversion programs and evaluating the associated costs and benefits. This will provide your Board with information to establish funding priorities and evaluate which programs to further pursue.

Mental health diversion generally occurs in five different stages of the criminal justice process (i.e., pre-arrest, arrest through arraignment, court proceedings and alternatives to incarceration, community reentry, and community support). Given the extensive scope of mental health diversion, and that some programs are currently in the process of being developed, we will report to your Board on each stage separately. The attached report (Attachment I) covers the first stage, pre-arrest law enforcement diversion. This report is intended to complement the District Attorney's August 4, 2015

comprehensive mental health diversion report. In consultation with your Board, we will evaluate and prioritize other diversion funding models, as required.

Review Summary

The Sheriff's Department (Sheriff) and the Department of Mental Health (DMH) are currently developing and implementing pre-arrest diversion programs. In general, the departments plan to grant specially trained law enforcement officers and teams the discretion to divert people exhibiting symptoms of mental illness to treatment instead of the arrest, booking, and incarceration process. Crimes subject to pre-arrest diversion generally include low level and non-violent offenses (e.g., drug possession, etc.).

The law enforcement officers and teams will transport diverted individuals to crisis drop-off centers that are available 24 hours a day. These centers will triage clients to identify underlying mental health conditions and stabilize symptoms. Clients are subsequently referred to other treatment services within the mental health system based on the level of care they need.

We noted that pre-arrest mental health diversion involves significant costs ranging from $6,000 to $220,000 per diversion, and in some limited circumstances (e.g., admission to State mental hospitals needed, etc.), over $1 million. Benefits include improvements in use of force, arrests, recidivism, community safety, and mental health and quality of life outcomes. We also noted that most of the pre-arrest diversion costs are from treatment services, which DMH also provides to non-diverted populations. Diversion just serves as another way of linking the mentally ill to available treatment. In addition, the Sheriff and DMH are exploring outside funding to cover most of the pre-arrest diversion costs (e.g., Mental Health Services Act, etc.).

We also noted that there is some uncertainty regarding the demand (i.e., number of potential clients) for pre-arrest diversion services, treatment utilization, and program outcomes. As a result, initially implementing pre-arrest diversion as a pilot project may be a practical approach. The Sheriff and DMH could establish measurable goals and objectives, track operations (e.g., resources, clients served, outcomes, etc.), and evaluate expanding or changing the program based on the results.

A detailed analysis of specific pre-arrest mental health diversion programs is included in Attachment I.

Acknowledgement

We discussed our report with Sheriff and DMH management, and thank them for their cooperation and assistance during our review. If you have any questions, please contact me, or your staff may contact Robert Smythe at (213) 253-0100.

JN:AB:RS:ZP

Attachment

c: Sachi A. Hamai, Interim Chief Executive Officer
Jim McDonnell, Sheriff
Dr. Marvin J. Southard, D.S.W., Director, Department of Mental Health
Jackie Lacey, District Attorney
Public Information Office
Audit Committee

MENTAL HEALTH DIVERSION PROGRAMS REVIEW
STAGE 1 – PRE-ARREST LAW ENFORCEMENT DIVERSION

Background

Mental health diversion services generally involve multiple programs designed to divert the mentally ill from the criminal justice system to appropriate treatment. At the pre-arrest stage, programs are focused on granting specially trained law enforcement officers the discretion to divert people exhibiting symptoms of mental illness to treatment instead of the arrest, booking, and incarceration process. Crimes subject to pre-arrest diversion generally include low level and non-violent offenses (e.g., drug possession, etc.).

Law enforcement officers transport the diverted individuals to crisis drop-off centers that are available 24 hours a day. These centers triage clients to identify underlying mental health conditions and stabilize the clients' symptoms. Clients are subsequently referred to other treatment services within the mental health system based on their required level of care.

Diverting the mentally ill prevents criminalizing behavior that may be outside their control and provides them with linkage to the treatment they need to manage their illness and decrease further interactions with law enforcement.

Review Scope

We collaborated with the Sheriff's Department (Sheriff) and the Department of Mental Health (DMH) to identify planned pre-arrest diversion programs, program objectives, levels of service, estimated costs, and potential benefits. Information is reported on a per person basis, given the uncertainties regarding the demand for services and the County's ability to provide the level of services required.

Diversion Programs

Three different pre-arrest diversion models are commonly used throughout the country to respond to situations involving the mentally ill: a specially trained law enforcement response, mobile mental health crisis team response, and combined response. The specialized law enforcement model generally provides a more rapid response while the mental health model is better-suited to manage and ease mental health symptoms. The combined response model shares similar characteristics of both the other models, but is generally more costly. The Sheriff and DMH have proposed to implement a specialized law enforcement response and combined response model, as follows:

Crisis Intervention Training

Crisis Intervention Training (CIT) is the most widely used method of implementing the specialized law enforcement response model. Officers receive approximately 40 hours

of training designed to help recognize symptoms of mental illness and respond in an optimal and appropriate manner. CIT generally includes topics such as mental health disorders and symptoms, psychotropic medication, substance abuse, crisis intervention techniques, and legal issues. CIT provides officers with the skills needed to deescalate hostile situations, minimize use of force, and divert people to treatment, if warranted.

The Sheriff intends to provide CIT to all sworn and non-sworn staff assigned to the four patrol divisions, Countywide Services Division, and the Transit Policing Division. The following is a summary of estimated CIT costs and staff receiving training:

TABLE 1

CRISIS INTERVENTION TRAINING - COSTS AND STAFFING			
SHERIFF DIVISIONS	**ESTIMATED COST**	**SWORN STAFF**	**NON-SWORN STAFF**
CENTRAL PATROL DIVISION	$ 3,942,645	867	118
NORTH PATROL DIVISION	3,872,843	850	121
SOUTH PATROL DIVISION	3,786,834	829	116
EAST PATROL DIVISION	3,247,163	705	108
COUNTYWIDE SERVICES DIVISION	3,566,555	579	429
TRANSIT POLICING DIVISION	2,378,398	497	138
TOTAL	**$ 20,794,438**	**4,327**	**1,030**

Most of the $20.8 million in CIT costs are from overtime related to backfilling shifts while staff are attending training. The Sheriff plans to provide CIT training to staff over a six-year period, incurring an average of $3.5 million in costs annually. The Sheriff indicated that CIT training for new staff assigned to the divisions after the six-year implementation period will be absorbed in their annual budget.

Mental Evaluation Teams

Based on the co-response model, the Sheriff and DMH have partnered to form Mental Evaluation Teams (MET), which pair specially trained patrol deputies with mental health clinicians to respond to calls for service or patrol requests for assistance involving the mentally ill. While these teams share similar crisis intervention methods as CIT (e.g., assessment, de-escalation, diversion, etc.), they generally perform in a more effective and efficient manner given deputy experience and training levels and the involvement of mental health clinicians. In addition to responding to emergent situations, METs build relationships within the community by maintaining active communication (e.g., reporting incidents, etc.), responding to concerns, and following up with prior clients to prevent future incidents.

The departments currently have eight METs and intend to expand service levels to 23 METs. The following is a summary of estimated annual MET costs and staffing:

TABLE 2

MENTAL EVALUATION TEAMS - ANNUAL COSTS AND STAFFING - 23 TEAMS			
COSTS		**STAFFING**	
SHERIFF'S DEPARTMENT:		**DIRECT STAFFING:**	
SALARIES & EMPLOYEE BENEFITS	$ 6,378,556	SHERIFF'S DEPUTIES	23
SERVICES, SUPPLIES, & EQUIPMENT	836,821	DMH PSYCHIATRIC SOCIAL WORKERS	23
TOTAL	**$ 7,215,377**	**TOTAL**	**46**
DEPARTMENT OF MENTAL HEALTH:		**MANAGEMENT & SUPPORT STAFFING: [1]**	
SALARIES & EMPLOYEE BENEFITS	$ 4,196,910	SHERIFF (VARIOUS)	14
SERVICES, SUPPLIES, & EQUIPMENT	547,481	DMH (VARIOUS)	13
TOTAL	**$ 4,744,391**	**TOTAL**	**27**
TOTAL ANNUAL COST:	**$ 11,959,768**	**TOTAL STAFFING:**	**73**

[1] Includes supervisors (e.g., sergeants, etc.), clinical advisors, analysts, and office staff.

Staffing is the majority of the $12 million in annual MET costs. The teams are staffed by Sheriff's deputies and DMH psychiatric social workers.

Mental Evaluation Bureau

The Sheriff and DMH are currently working toward establishing a Mental Evaluation Bureau (MEB). The proposed MEB will triage calls from patrol personnel involving the mentally ill to determine whether the patrol personnel can handle the incident on their own and transport the person to treatment services or higher level METs are necessary. The MEB will also be involved in providing case management services to the mentally ill who have frequent law enforcement contacts, crisis negotiations, training department personnel (e.g., CIT, etc.), tracking diversion data, and community relations.

Diversion Treatment Programs

CIT and MET program staff will divert mentally ill clients to DMH Urgent Care Centers, which will serve as a single entry point into the mental health system. The centers will provide mental health assessment, crisis stabilization, and treatment services (including substance abuse). Since centers can only provide care for less than 24 hours at a time, clients are triaged and subsequently referred to appropriate community-based treatment programs. The following treatment programs receive referrals (listed from most to least intensive treatment):

- **State Mental Hospitals:** Secure long-term care psychiatric facilities for clients who cannot function in any of the lower levels of care below due to the severity of their symptoms and behavior. If needed, clients may be placed in seclusion or restraints, and given intramuscular medication. It should be noted that the clients must generally be placed under a Lanterman Petris Short (LPS) conservatorship to be admitted to these facilities. An LPS conservatorship assigns responsibility for overseeing a client's comprehensive medical treatment to another entity (e.g., Public Guardian, family, etc.). The conservatorship process generally involves an inpatient psychiatric hold at a hospital while a determination is made (through

the courts) on whether the client's mental health condition prevents them from providing for the basic needs of food, clothing, and/or shelter.

- **Institutions for Mental Diseases:** Secure long-term care psychiatric facilities for clients who are in need of intensive residential treatment services (cannot live independently or in board and care facilities). Treatment is generally focused on promoting client awareness, managing client symptoms, and preparing clients for transition to lower levels of care. It should be noted that clients must generally be placed under an LPS conservatorship to be admitted to these facilities.

- **Crisis Residential Treatment Programs:** Short-term (no longer than 14 days) residential treatment facilities for clients experiencing an acute psychiatric crisis. Treatment is generally focused on stabilizing current crisis episodes, developing relapse prevention and independent living skills, linking clients to social services (e.g., housing, medical, etc.), and reintegrating clients back into the community.

- **Full Service Partnerships:** Intensive wrap-around services that help clients live successfully in the community. Multi-disciplinary teams work with clients to reach specific recovery, wellness, and independence goals. Services include mental health and medical treatment, and assistance with quality of life activities (e.g., housing, employment, education, relationships, etc.).

- **Field Capable Clinical Services:** Similar services as Full Service Partnerships for clients who require lower levels of care (e.g., lower intensity, less visits, etc.).

- **Wellness Centers:** Outpatient facilities (staffed by mental health professionals and peers) for clients in higher stages of recovery who do not need the intensive services offered by other programs. Clients participate in activities that facilitate wellness planning (e.g., prevention strategies, etc.), healthy living, and community integration. Staff also assist clients in accessing supportive social services (e.g., housing, etc.).

We have included a summary of the estimated costs and lengths of service for mental health treatment programs below. Information is reported on a per person basis, given the uncertainties regarding the demand for services and the County's ability to provide the level of services required.

TABLE 3

MENTAL HEALTH TREATMENT PROGRAMS - COSTS AND LENGTHS OF SERVICE

MENTAL HEALTH TREATMENT PROGRAMS	AVERAGE DAILY COST	AVERAGE DAYS IN PROGRAM	AVERAGE TOTAL COST PER CLIENT	AVERAGE ANNUAL COST PER CLIENT
URGENT CARE CENTERS	$ 417	1	$ 417	$ 417
STATE MENTAL HOSPITALS	626	2,008	1,319,667	239,939
INSTITUTIONS FOR MENTAL DISEASES	250	225	99,992	99,992
CRISIS RESIDENTIAL TREATMENT PROGRAMS	422	12	5,064	5,064
FULL SERVICE PARTNERSHIPS	68	1,095	74,460	24,820
FIELD CAPABLE CLINICAL SERVICES	38	913	34,694	13,878
WELLNESS CENTERS	9	N/A	N/A	3,200

Note 1: Wellness Center clients receive intermittent treatment and may continue to receive services throughout their lives.

Note 2: For State Mental Hospitals and Institutions for Mental Diseases, LPS conservatorship process costs (e.g., hospital stay, etc.) are included in the average total and annual costs per client.

Urgent Care Centers will refer clients to the appropriate treatment program based on the level of care they need. Clients can also transition from one treatment program to another depending on their progression towards recovery. For example, a client can be initially referred to Full Service Partnerships then eventually transition to Field Capable Clinical Services when their mental condition improves. However, no data is available on the extent of referrals and transitions between treatment programs (e.g., percentage of Crisis Residential clients that subsequently transition to Full Service Partnerships, etc.). As a result, the average treatment cost per diversion cannot be identified.

Cost Analysis

As indicated earlier, average costs per diversion cannot be reliably identified due to the lack of available data, uncertainty over demand for services, (i.e., number of potential clients), and program changes (e.g., new programs, program expansion, etc.).

However, we were able to develop general estimates of average costs per diversion based on diversion statistics in other jurisdictions and characteristics of the clients served. We segmented clients into two categories: clients who generally manage their mental health symptoms well, but occasionally experience acute psychiatric episodes (acute clients), and clients who continually struggle with managing their symptoms and have not received sufficient treatment (chronic clients). While the former may only need crisis stabilization services, the latter frequently need ongoing treatment with wide ranging levels of care. We identified the upper and lower levels of care that the chronic clients would generally need, and a maximum level of care for the limited number of chronic clients with highly severe symptoms and behavior. The following is a summary of the estimated average costs per diversion:

TABLE 4

ESTIMATED AVERAGE COSTS PER DIVERSION	
AVERAGE COSTS PER DIVERSION BY CLIENT TYPE	
ACUTE CLIENTS	$6,000 - $11,000
CHRONIC CLIENTS (LOWER RANGE OF TREATMENT NEEDED)	$41,000 - $46,000
CHRONIC CLIENTS (UPPER RANGE OF TREATMENT NEEDED)	$215,000 - $220,000
CHRONIC CLIENTS (MAXIMUM RANGE OF TREATMENT NEEDED)	OVER $1 MILLION
PORTION OF AVERAGE COST ATTRIBUTABLE TO DIVERSION SOURCE	
CRISIS INTERVENTION TRAINED DEPUTIES	$400
MENTAL EVALUATION TEAMS	$5,000

Note: Ongoing Wellness Center annual costs of $3,200 not included.

Most of the costs involved in mental health diversion are related to treatment services. While the costs are significant, DMH provides similar treatment services to non-diverted populations as well (not just people encountering the criminal justice system). As a result, CIT and MET diversion just serve as another method of linking the mentally ill to DMH's available treatment services.

Additional Costs

The estimated average costs per diversion calculations only include the primary costs of diversion (i.e., CIT, MET, and treatment programs). Many of the clients will also need supportive social services (e.g., housing, employment, healthcare, alcohol and drug services, etc.) to assist with their recovery. While the treatment programs provide some supportive services, they may not cover all of the clients' needs and clients may still need services after leaving programs. As a result, there are additional costs associated with diversion that will vary depending on the different types of services the County elects to provide to clients and the differences in client needs.

The calculations are also based on the County maintaining sufficient capacity at Urgent Care Centers to match the demand for services. If demand exceeds capacity, hospital emergency rooms would need to manage the overflow at much higher costs.

County Cost Reductions

DMH and the Sheriff are exploring outside funding to cover most of the diversion costs. DMH is evaluating potential funding sources for treatment services, including the Mental Health Services Act and Mental Health Wellness Act. The Sheriff is assessing whether CIT could be included in the State-funded Peace Officer Standards and Training.

While diversion costs may be covered by outside funding sources, it is difficult to actually reduce most cost components. For example, treatment services are primarily provided by vendors at fixed rates. However, there is potential to reduce CIT costs. The Sheriff plans to provide CIT to all department personnel in their six public-facing

divisions (e.g., patrol, etc.), which is significantly higher than some other agencies. The agencies we contacted generally provide CIT to between 25 and 40 percent of their personnel. They request volunteers, conduct specialized interviews and psychological testing, and select candidates who would be the best fit for the program (e.g., strong interpersonal skills, agreeable attitudes, etc.). The agencies only need to train enough staff to appropriately respond to projected mental health calls for services. The Sheriff indicated that they have decided to provide CIT to all personnel due to the critical tools acquired through the training and to ensure consistency throughout the department.

Benefit Analysis

Pre-arrest diversion targets low level and non-violent offenders. With the exception of limited circumstances (i.e., misdemeanants incompetent to stand trial), these offenders spend minimal, if any, time in County jail. Consequently, the pre-arrest diversion model does not appear to generate any material cost savings from avoiding incarceration. However, pre-arrest diversion does provide potential benefits, including improvements in use of force, arrests, and recidivism.

Use of Force

People with mental illness may display erratic and unusual behavior (e.g., not following commands, irrational speech, etc.) during encounters with law enforcement which leads to a greater exposure to use of force situations compared to the general public. Use of force situations involve several risks, including offender and officer injuries, litigation and monetary damages, community loss of confidence in law enforcement, and diminished public safety. When these risks materialize they can be significant. For example, the Sheriff incurred $17 million in use of force judgments and settlements and over $100 million in workers' compensation expenses in 2014. In addition, recent shootings of mentally ill individuals by law enforcement in other agencies have contributed to intense public scrutiny throughout the country.

CIT and MET officers are specially trained to deescalate hostile situations and minimize use of force, when appropriate. Studies have shown traditional officers are more than twice as likely to use physical force compared to specially trained CIT and MET officers. Offenders are also more than five times as likely to be injured when physical force is used by traditional officers. CIT and MET officers appear to have the skills needed to more effectively and safely resolve hostile situations using less physical force.

Arrests

Arrest rates for people with mental illness are double that of other criminal suspects, and the arrests are typically related to minor and non-violent offenses (e.g., property crime, disorderly conduct, etc.). A potential explanation for the arrest discrepancy is that officers lack knowledge of mental health disorders and symptoms, and the techniques needed to effectively address individuals exhibiting unusual behavior. Mental health disorders are associated with symptoms (e.g., belligerence, verbal abuse,

disrespect, paranoia, etc.) that may provoke officers to respond in a more punitive manner. Lack of available treatment programs to accept offenders from law enforcement is also a contributing factor to the arrest discrepancy. Arrests do little to resolve the underlying mental health condition causing the disruptive behavior. Offenders who do not receive appropriate treatment are likely to encounter law enforcement again, continuing a cycle of arrests.

Pre-arrest diversion programs that use specially trained law enforcement officers (e.g., CIT, MET, etc.) and crisis drop-off centers have reduced arrest rates for the mentally ill. Within five years of implementing a similar program, arrest rates in one jurisdiction were reduced by 85 percent when specially trained officers responded to mental disturbance calls for service. An average of three percent of mental disturbance calls for service resulted in arrest.

Recidivism

One of the primary objectives of pre-arrest diversion is to reduce clients' future contact with law enforcement by providing them with the treatment and social services they need to improve their lives. Studies of pre-arrest diversion programs have shown significant to no noticeable success in meeting this objective. These variations are generally due to differences in the quality, range, and availability of supportive services provided. Some of the more effective pre-arrest diversion programs have seen client arrests decrease by 65 percent the year after they were diverted compared to the year before they were diverted.

Other Benefits

Most of the research related to pre-arrest mental health diversion focuses on benefits from a law enforcement perspective (e.g., arrests, recidivism, etc.). However, very little has been dedicated to other potential positive outcomes. Many authorities on pre-arrest diversion believe that it leads to improvements in client mental health functioning, client quality of life (e.g., housing, employment, etc.), community safety, and public awareness of mental illness.

Sobering Centers

Although not targeted to the mentally ill population, there has been interest in diverting intoxicated people to sobering centers instead of hospitals and jails. Mental illness is frequently accompanied by drug or alcohol abuse. Sobering centers are 24-hour facilities that provide a safe and supportive environment while the effects of intoxication subside. Clients are brought to the sobering centers by ambulance and law enforcement, and are provided with beds, food, clothing, and hygienic needs. Many centers are also staffed with nurses and other medical practitioners who monitor client vital signs and provide medical care (e.g., injuries, etc.). The centers cost between $50 and $250 per client visit, depending on the level of medical care provided.

The primary goal of the sobering centers is to provide quality care, stabilize clients, and refer them to additional detoxification and treatment services, when necessary. Benefits include reduced use of emergency and law enforcement services (higher costs), and better outcomes for chronic inebriates.

Review Summary

Pre-arrest diversion involves significant costs ranging from $6,000 to $220,000 per diversion, and in some limited circumstances (e.g., admission to State mental hospitals needed, etc.), over $1 million. Benefits include improvements in use of force, arrests, recidivism, community safety, and mental health and quality of life outcomes. We also noted that most of the pre-arrest diversion costs are related to treatment services, which DMH also provides to non-diverted populations. Diversion serves as another way of linking the mentally ill to available treatment. In addition, DMH and the Sheriff are exploring outside funding to cover most of the pre-arrest diversion costs.

We also noted that there is some uncertainty regarding the demand for pre-arrest diversion services (i.e., number of potential clients), treatment utilization, and program outcomes. As a result, initially implementing pre-arrest diversion as a pilot project may be a practical approach. DMH and the Sheriff could establish measurable goals and objectives, track operations (e.g., resources, clients served, outcomes, etc.), and evaluate expanding or changing the program based on the results.